Pinchot Family Medicine, P.C.

PATIENT NAME (PRINT):____

BENEFICIARY NAME (PRINT):____

FINANCIAL AGREEMENT, ASSIGMENT OF BENEFITS AND RELEASE OF MEDICAL RECORD(S)

ALL Patients' / Authorized Person's Signature Required:

Insurance Authorization and Assignment:

“I authorize that payment be made directly to the doctor for all medical, surgical, and hospital benefits entitled to me. I understand that I am financially responsible to the doctor for charges not covered by this assignment and/or remaining (outstanding) balances.”

(Guarantor Signature)___________________________________(Date)___________________

ALL Patients' / Authorized Person's Signature Required:

“I agree that if I do not pay my full account balance within 30 days, Pinchot Family Medicine, P.C. may refer this account to its collection agency, and/or attorneys, for colleciton efforts. I will also be responsible for, and agree to reimburse Pinchot Family Medicine P.C. for any and all reasonable collections fees (currently 25% of unpaid balance due), including legal fees, filing fees, interest, service cost, and disbursement incurred as a result of the collection efforts.”

Medicare Patient or Authorized Person's Signature:

“I request that payment of authorized Medicare benefits be made either me or on my behalf to the name of provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service.”

(Guarantor Signature)____________________________________(Date)__________________

Medicare/Medigap Patient (Secondary Insurance) or Authorized Person's Signature:

“I request that payment of authorized benefits be made either to me or on my behalf to the provder of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) ________________________________ any information needed to determine these benefits payable for related services.”

(Guarantor Signature)____________________________________(Date)___________________